NEWS

Think again on bill, say leaders of half a million NHS staff

"It is in the interest of all to ensure that the whole NHS is not the subject of a gigantic experiment with a high risk of failure."

This warning comes from over 20 professional organisations including the medical and nursing royal colleges and faculties, which call for the government to rethink the NHS and Community Care Bill as it enters the House of Lords. The second reading is scheduled for the first week in April. The professions want the bill's proposals to be introduced in no more than two regions while they are evaluated.

Launching *The Way Forward for the NHS* at a press conference on 27 March, the chairman of the conference of medical royal colleges and faculties, Professor E D Williams, called for evaluation by an advisory council that would report to the new, soon to be appointed chief of research and development. The colleges want the government, the professions, and the public to be represented on this council.

While welcoming the white paper's aims the signatories to the document—representing over half of the million staff in the NHS—argue strongly that there is no evidence that the changes will improve health care and call for adequate resources to be made available.

"We are ready to support proposals if properly costed and funded which can be shown to provide a better service. We do not support untested proposals, which we seriously believe will damage a service whose main defects are due to historic underfunding rather than defective organisation."

The professions do, however, accept the need for better information technology and support the emphasis on professional audit.

The group first collaborated last December after the Prime Minister refused to meet their representatives to discuss concerns about the bill (9 December 1989, p 1421). *The Way Forward* re-emphasises the professions' repeated warnings that the introduction of the changes in the way proposed by the government will disrupt the NHS. They warn that there is no evidence

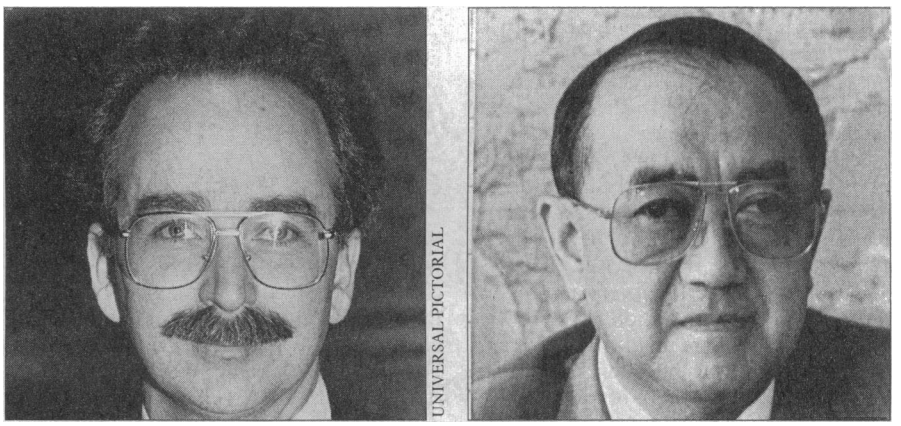
- That personal gain provides a better incentive to ensure a high standard of medical care than does professional dedication to a properly organised and financed NHS
- That the proposed internal market will improve the standards of or access to patient care
- That the introduction of self governing hospitals will improve patient care
- That allowing terms and conditions of service of professional staff to be fixed locally will improve the service
- That the introduction of fund holding practices will itself improve patient care
- That forcing teaching hospitals and medical schools to spend large sums on costing and billing will improve patient care or medical education and research.—LINDA BEECHAM

Mann overboard

This week Dr Michael Merson, director of the World Health Organisation's diarrhoeal diseases control programme, was due to become acting director of the organisation's global programme on AIDS after the current director, Dr Jonathan Mann, "decided not to accept renewal of his WHO contract when it comes to an end on 14 June 1990." The words belong to Dr Mann's boss, Dr Hiroshimi Nakajima, director general of the organisation, with whom Dr Mann has had a very public falling out over the direction of the organisation's AIDS strategy.

Dr Mann, a 42 year old American doctor, joined WHO in 1986 to set up its AIDS programme. Since his arrival it has become the organisation's most visible programme, with a staff of about 200 and an annual budget of $109m.

In a remarkably outspoken press interview with the French newspaper *Le Monde* (23 March), Dr Mann accused the director general of a lack of commitment to the AIDS programme that was "completely paralysing our efforts." Certain initiatives, he claimed, had not been acted on. He cited his proposal, made four months ago, to remind member states of a World Health Assembly resolution on non-discrimination against AIDS victims and to invite them to ensure the necessary legislation. He also referred to a declaration made last May by the World Health Organisation's Global Commission on AIDS to the effect that anti-AIDS drugs and an eventual vaccine should be made available to all countries, not just the affluent ones.



Dr Mann (left) said that under Dr Nakajima it was "practically impossible to turn words into concrete actions"

The rift between the two men may be partly explained by the organisation's current philosophy, embodied in its slogan —"Think globally, act locally." Dr Nakajima is strongly in favour of decentralisation and spoke approvingly at last week's Global Commission on AIDS of how the process was beginning to give increased responsibilities to the regions and to countries. Dr Mann seems to have been in favour of more centralised control. The two men reportedly clashed over how the problem of AIDS in eastern Europe should be handled, with Dr Mann wanting to run the programme directly through Geneva rather than through the European AIDS office in Copenhagen (*Independent*, 17 March).

Assisting Dr Merson until the appointment of a new director, to be announced at the World Health Assembly in May, will be Dr Walter Dowdle, deputy director of the Centers for Disease Control in Atlanta, Georgia, and formerly responsible for the centres' control activities. Top of their list of problems is deciding how WHO should respond to the calls for a boycott of the sixth international conference on AIDS in San Francisco in protest at the United States's discriminatory immigration policy towards people infected with HIV.—PHILIP SELBY

Consensus on research into fatigue syndrome

At Green College, Oxford, on 23 March about 20 researchers and clinicians, convened by three psychiatrists and chaired by a fourth (Professor Anthony Clare), spent a day pursuing the elusive quarry of a consensus on guidelines for the future study of the chronic fatigue syndrome and its subtype, the post-infectious fatigue syndrome (box). Note that the term "viral" has gone. As a convenor said, the meeting had the "ambitious but fairly realistic aim of arriving at guidelines for research that if followed will lead to scientifically valid papers that are worth reading and should reduce the difficulty of comparing studies between disciplines."

The term "ambitious" was certainly justified by the wide spread of representation from biochemistry, virology, psychology, neurology, psychiatry, muscle physiology, general practice, immunopathology, magnetic resonance imaging, and anthropology. A lexicographer would have been useful too because participants were soon into a deep discussion about the semantics of the various descriptions of the physical and mental fatigue that is the key symptom of the syndrome(s). Although the pragmatists were happy to rely on the *Oxford English Dictionary*, the first recommendation of the meeting was that an appropriate research glossary should be prepared to pin down the thesaurus of exhaustion, langour, lassitude, and the rest suffered by patients, particularly after exertion.

For a syndrome in which patients report a catalogue of symptoms "like the first two or three chapters of *Cecil Loeb*" it was difficult to decide which symptoms, apart from fatigue, were the key ones. But myalgia, sleep and mood disturbances, and reports of feeling hot or cold were the strongest contenders; the meeting advised that researchers should pay attention to and report on these and all other symptoms. There was agreement that there are no diagnostic signs.

Without crucial signs or a defined set of key symptoms selection of patients for studies of these fatigue syndromes depends on the exclusion of medical conditions known to produce fatigue. The main stumbling block here was depression. In the opinion of one psychiatrist exclusion of depressive illness would lead to a "vanishing study group," whereas others said that there were plenty of patients with the chronic fatigue syndrome who were not depressed and exclusion of those with depression would "purify" the study sample. All agreed, however, that researchers should give information about what types of patients they had excluded. Some strongly recommended that excluded patients should be used in comparison groups —to improve the choice of control groups, which one participant described as being "faulty in every study so far." No one comparison group (for example, "healthy" people) is usually adequate. Other comparison groups could include those with neuromuscular disorders, conditions causing inactivity, or depressive disorder.

The final version of the consensus will be published. Professor Clare's masterly chairmanship and the wide terms of reference, however, elicited most of the recommendations by the end of the morning. But as the afternoon wore on and fine distinctions continued to be made by the lumpers and splitters, the chairman, with an uncharacteristic trace of exasperation, suggested that it was time for the real object of the chase to break cover. There was, he said, only one reason for calling the meeting and that was "a group of patients with a cluster of symptoms who get a lot of publicity."

It is impossible to forecast whether the consensus recommendations will help researchers and clinicians get to grips with ME, as it is known by the public, but the requirements set for the conduct of future studies should make it more likely that they pick up the same scent. —JANE DAWSON

Proposed definitions

Chronic fatigue syndrome

(*a*) A syndrome characterised by fatigue as the principal symptom
(*b*) A syndrome of definite onset (that is, not life long)
(*c*) The fatigue is severely disabling and affects physical and mental functioning
(*d*) Other symptoms may be present, particularly myalgia, mood disturbances, and sleep disturbance
(*e*) A minimum of six months' of fatigue present for more than 50% of the time.

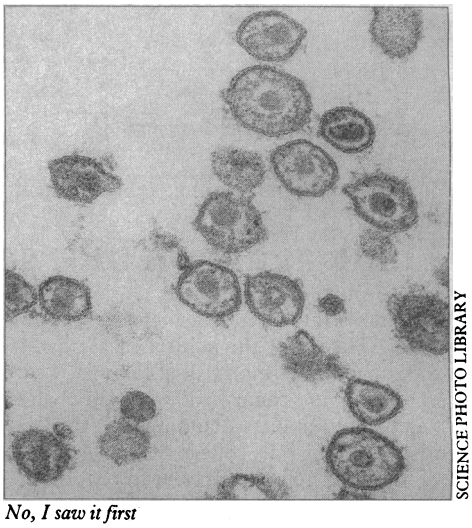
Post-infectious fatigue syndrome

Chronic fatigue syndrome but with definite evidence (patient's reports are unlikely to be sufficiently reliable) of infection at onset or presentation:

(*a*) Present for more than six months after onset of infection or after resolution of clinical signs associated with acute infection
(*b*) The infection has been corroborated by clinical signs or laboratory evidence.

AIDS priority dispute goes on

Will it never fade or pass? Well, no—not while millions of dollars hang on the outcome. Professor Luc Montagnier of France's Pasteur Institute says that Professor Gallo of the United States National Institutes of Health should "submit to the evidence" and recognise that the AIDS virus he claims to have discovered in 1984 is in fact a virus that was identified several months earlier at the Pasteur Institute. Professor Montagnier also considers that it is "immoral" that Americans who share patent rights for the diagnostic test based on the virus are receiving royalties while French researchers haven't received anything.



SCIENCE PHOTO LIBRARY

No, I saw it first

The AIDS virus affair has been revived by an investigative article in the *Chicago Tribune*, stating that existing documents prove that Professor Gallo is not the discoverer of the virus, which he called HTLV 3. It is in fact the same virus that was identified at the Pasteur Institute a few months earlier, and of which a sample was provided to the American team. The article has triggered another investigation, now under way in the United States.

There is no doubt, says Professor Montagnier, that Professor Gallo's HTLV 3 is the same virus as the one he had identified earlier. In a long interview with *Le Monde* Montagnier said that his virus may have contaminated viral cultures in Professor Gallo's laboratory and then was erroneously identified as a new virus. In answer to a question he said, "If there has been fraud, it is up to the American investigation to show it . . . . The charge is very serious, and for the time being I refuse to make it."

The AIDS virus dispute entailed more than the recognition of the first discoverer. After its first publication of the finding in the American journal *Science* in April 1984 the Pasteur Institute applied for a United States patent on a diagnostic test, and Professor Gallo applied for a similar patent a few months later. After Gallo's demand was granted while the Pasteur Institute's was not a feud erupted between the institute and the National Institute of Health, which was settled only in 1987 during a personal meeting between Jacques Chirac, then France's prime minister, and United States president Ronald Reagan.

A later agreement provided for the sharing of royalties and the establishment of an AIDS research fund. Members of Professor Gallo's team have been receiving their share of royalties, while the French researchers' royalties have so far been absorbed by the reimbursement of legal costs.

The director of the Pasteur Institute Maxime Schwartz, said on 20 March that the 1987 Franco-American agreement could be challenged if the current investigation disproves Professor Gallo's claims. —ALEXANDER DOROZYNSKI

Counting homeless Americans

Americans are about to be counted in the decennial census at a cost of $2·6 billion, and counting them is getting more difficult because of increasing mobility, more illegal immigrants, and more people without homes. Yet the results are getting more accurate: the Census Bureau estimates that the population was 1·4% higher in 1980 than the 226·5 million it reported, 2·9% higher than the figure reported in 1970, and 3·3% higher than the 1960 figure.

The group that may be the most difficult to count are the homeless, and 15 000 enumerators spent one day last week documenting the age, race, and various other characteristics of all the homeless that they could find. The enumerators were working from 22 000 sites across the country, including shelters, abandoned buildings, all night theatres, restaurants, drug and alcohol detoxification centres, emergency rooms, and (in California) foothill caves. The homeless were asked to fill out the forms themselves unless unwilling or unable to, and if the enumerators encountered people who were incoherent, uncooperative, or asleep they simply noted their age, race, and sex and left.

Estimates of the number of homeless people in the United States vary from 250 000 to three million, illustrating why a count is needed.

Advocates for the homeless are mostly keen that the homeless should be counted—because government funds for the homeless will be based on the count—but they are worried that there will be gross undercounting. The advocates are particularly concerned that places like subway tunnels, which are popular among the homeless, are not included in the count.—RICHARD SMITH

A NEEDLER/NEWPORT SURVEY

Chances of losing a baby vary more than twofold countrywide

Maternity services could do better

Measuring the efficiency of maternity services in Britain has proved elusive for the National Audit Office because of a general lack of reliable data. But wide variations in hospital facilities and staffing ratios lead to the suspicion, in a report last week, that the service is deficient in some areas but more than is strictly necessary in others (table).

The office concludes that health authorities need to do more to reduce infant mortality figures in localities where they remain significantly above average, and to show that all high risk pregnancies are identified. More could be done, for example, to release resources for neonatal intensive care.

While the National Audit Office's analysis confirms the view that high or low mortality cannot be explained by socioeconomic factors alone, the report urges health authorities to adopt a more positive approach to problems rooted in these factors. Most clinicians interviewed suggested that social and economic condititions were the main factors. Admitting that above average perinatal mortality is likely to be associated with above average levels of social and housing deprivation, the office also found that at local level few authorities are taking positive steps to address such problems.

The office reports a trend towards greater provision of intensive care, which is partly offset by reduced facilities for special care. There was some evidence of increasing demand outstripping increasing provision. Though there can be problems in finding a suitable cot, 85% of districts replying to a questionnaire stated that they had been able to find cots for sick newborn babies within three hours.

Sixty years ago about 95% of mothers gave birth at home. Now about 99% of births are in hospital. The NHS spends about £700m a year on maternity services, or £930 for each of 750 000 babies born. Cost estimates for intensive care range from £199 to £777 a day, but because of the rudimentary costing systems in use these are not a reliable guide.—JOHN WARDEN

Maternity Services, a report by the Comptroller and Auditor General, National Audit Office, is available from HMSO, price £5.

Perinatal mortality in 1986-8 by health authority

Authority	Mortality/1000 births
Lowest	
Huntingdon	5·1
Oxfordshire	5·3
South Warwickshire	5·8
Cambridge	5·9
West Essex	6·3
East Hertfordshire	6·4
Bromley	6·5
West Surrey and North East Hampshire	6·5
Highest	
Bradford	13·5
Burnley, Pendle, and Rossendale	13·1
Wolverhampton	12·6
East Birmingham	12·5
Scunthorpe	12·3
Newham	11·9
Walsall	11·7
Ayrshire and Arran	11·5
North Staffordshire	11·3

LMC conference on contract preserves status quo

As an exercise in democracy it may have been a success, but if grassroots general practitioners saw last week's special conference as an opportunity to persuade their allegedly "out of touch" General Medical Services Committee (GMSC) negotiators to take a militant stance they will have been disappointed. Despite some angry speeches reflecting constituents' frustrations the conference of local medical committees in the end did no more than endorse the GMSC's policy over the imposed contract, which has been painstakingly put together over the past year (p 880).

The conference did manage to get the day's key motion—one of no confidence in the GMSC as negotiators—rescheduled from the afternoon to almost the first motion of the day but then failed to pass it. Motions about undated resignations from the NHS and judicial reviews over the contract's imposition similarly failed to attract sufficient support. The nearest to an upset for the platform occurred when a motion demanding that general practitioners be balloted about sanctions was lost by five votes. After months of debate, legal opinions, and a special study of the topic the GMSC had rejected them on the grounds that no legal sanction could be devised that did not harm patients, doctors, or the NHS.

All that doctors could do was to monitor the defects of the new contract, expose them as they arose, and use that evidence to negotiate changes in the contract. To this end red cards—to report adverse contract reactions—should be on every GP's desk within a few weeks.

After the contentious proposals were out of the way the conference approved a series of motions, virtually unanimously, against the actions of the Secretary of State for Health and the new contract. It may have helped the "resentment, bitterness, and frustration"—as GMSC chairman, Dr Michael Wilson, described the general feeling among GPs—

but the unpalatable truth was that in law the secretary of state has extensive powers when it comes to changing general practitioners' contracts, particularly when, as in this parliament, his party has an unassailable majority.

The imposition of the general practitioners' contract was another exercise in this government's drive to open the professions to the winds of competition and supposedly provide customers with a better service. At least the conference showed—from its members' practical experience—that this attempt to sharpen competition is more likely to harm than help the service to patients.—TONY DELAMOTHE

Debate on self governing trusts

Arguments about the propriety of introducing self governing trusts into the NHS still rage more than a year after the idea was first formally mooted—partly because the government has yet to expose much of its hand. Last week it was the turn of the deans of the medical schools and chairmen of medical executives to debate the new proposals at a University Hospitals Association meeting at Southampton General Hospital.

Speaking for the introduction of trusts was Dr Hugh Saxton, chairman of the Guy's Hospital management board. He believed that it was untenable for opponents to say that they would rather stay as they were. He did not think that teaching and research would be jeopardised or the links of a hospital with its community harmed. Neither would medical involvement in management be threatened. If anything the influence of doctors was going to be enhanced. In terms of "naked self interest" and doctors' own contracts, he supposed that it was true that the status quo was more comfortable for most people. But equally there were fewer opportunities for people to do well and there was "less to stimulate the idle," and there were a few such characters around.

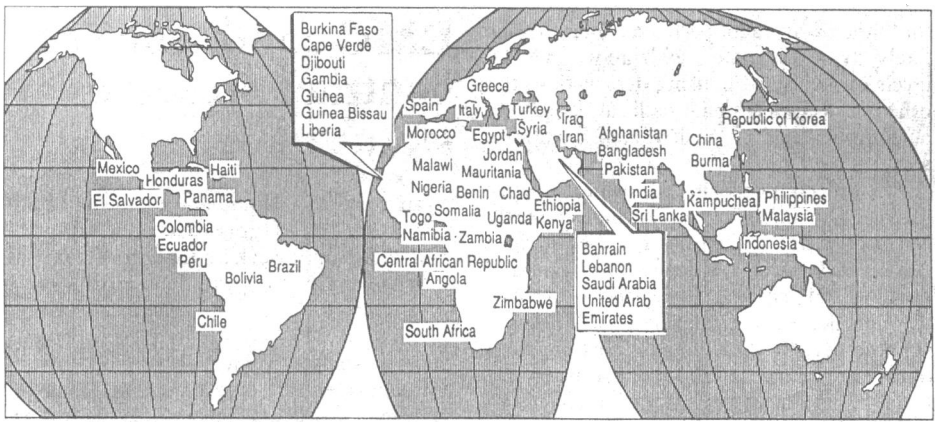
The idea that self governing hospitals would concentrate just on hi-tech medicine was insulting to the doctors concerned. Local people would be able to get the same service from the hospital and the trust would be legally obliged to provide it. General practitioners were already self governing. People did not think they were particularly dreadful in their approach to life.

There were good arguments against opting for self governing status if the hospital was poorly organised, information systems were inadequate, and there was a high torpidity index. Finally, Dr Saxton discounted the argument that "people with teeth" would be taking over the organisation of a hospital and changing it so rapidly that none of the existing staff would be able to work there.

Very much in the opposing camp was Professor John Dickinson of St Bartholomew's Hospital. To him many aspects of the marketplace proposals in the NHS bill were totally distasteful. They would wreck a good and economic system. He agreed with a comment from the audience that the profession had been disgracefully supine about accepting the reforms. Though he thought that the BMA had overdone it, the rest of the medical bodies had gone down without a whimper. Trusts were the first fundamental step towards dismantling the service, and the new arrangements far from freeing patient choice would restrict it greatly. A major problem, he said, was to improve NHS management. If the trusts were able to recruit first class managers he would modify

Helping torture victims gets harder

Amnesty's torture* map (1988)



* as defined by Article 1 of the UN declaration against torture (1975)

As if the Medical Foundation for the Care of Victims of Torture wasn't under enough pressure. For on a shoestring budget with only 16 paid staff and 40 volunteers the foundation has been finding it increasingly difficult to keep abreast of the growing demand for its services—each week about 95 people who have fled to Britain after being tortured in their own countries are provided with advice and support (9 September 1989, p 641).

But it is not the growing demand from these exceptionally disadvantaged people that has nearly brought the foundation to its knees. It is Bloomsbury Health Authority that has that dubious distinction. The reason is that having leased the foundation (free of charge) modest premises in a disused wing of the National Temperance Hospital for several years, it has suddenly given notice to quit. "Of course we knew that we could not stay there for ever, and we are most grateful to the authority for letting us live (effectively) rent free over the past five years," said the foundation's director, Helen Bamber. "What has shaken us is the suddenness of their demand." (The foundation received its curt letter from the health authority's solicitors advising it that it must vacate the premises by 17 March two months ago.) "And the fact that the authority has rescinded an offer made [verbally] last December of alternative accommodation in another wing of the hospital."

After receiving the eviction order the foundation appealed to the health authority to grant it a six to nine month reprieve—how long it would take to find, and to buy, suitable new premises. Letters sent on 2 February to the chairman of the authority and its director of public health received no reply.

The 17 March deadline came and went and anxious speculation about the future of the organisation has been temporarily assuaged by an eleventh hour offer of a six week extension. (It is also possible that "temporary" accommodation in another hospital will be offered.) This short lived reprieve is being used by the foundation to launch a nationwide appeal for funds (£1m is needed) to buy another base. And the hunt is on to find suitable premises; a small disused hospital or school in central London would be ideal.

The uncertainty surrounding the future of the foundation is not merely taking its toll on staff morale. "Our clients are anxious too," said Helen Bamber. "Their lives have been dominated by fear and insecurity and for some this questionmark over our future seems like the last straw. You see, we have become a spiritual home as well as a practical base for these people. We can't let them down."—TESSA RICHARDS

The address for the emergency appeal is: Medical Foundation Emergency Appeal, Devonshire Clinic, Freepost, London W1E 3EZ. Appeal Pledge line: 01 388 8204. Further information may be obtained from the press officer, Jenny Watson (01 388 8204 or 01 383 3146).

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his opposition. He was convinced that the top hierarchy was employing bogus incentives to beguile managers into accepting the idea. Both the promise of goodies to come and veiled threats were never put in writing. As no firm commitments were being made there could be no recriminations if the plan did not unfold as outlined.

Professor Dickinson thought that the drive and manipulative ability of the secretary of state should be applauded, but none the less the profession should not meekly stand by. If very few hospitals opted for self governing status there would have to be a political rethink. It was perfectly reasonable to sample the opinions of the public and professions in a ballot before setting up a trust.

Doctors, while expected to support trusts, were being left inthe dark about many of the important financial aspects. He pointed out that the legislation would permit a hospital to turn itself almost exclusively private if it so wished and expressed the view that trusts would create ill feeling among staff from different institutions who had traditionally cooperated.

Without firm insistence from Mr Clarke self governing hospitals would be tempted to regard teaching and research as optional extras and fill their beds with cold surgery cases. This would be a complete reversal of today's difficult position where cold surgery was frequently being halted because of the imperative to fill beds with medical emergencies. He doubted that the secretary of state would intervene sufficiently at the outset to ensure the continuance of vital core services or maintain an adequate case mix.—PETER MERRY

Letter from Westminster

Conscience clause divides MPs and doctors

Eight non-politically motivated doctors lined up as witnesses before the Commons social services committee last week. Four were liberal and four were conservative. Note the small "l" and the small "c," since these are not party labels but denote attitudes towards the Abortion Act and the operation of the conscience clause.

The issue is one that disturbs and divides the profession perhaps more than it realises, and certainly more than the Department of Health realised from the bland evidence it produced, based on deceptively few complaints (20 January, p 145). Judging from the balance of evidence the committee has received there is a strong likelihood that it will propose changes in the operation of the conscience clause because it tends to disadvantage doctors who invoke it as well as women who seek a termination.

But that is conjecture on my part and there are ample signs that the MPs are almost as deeply divided as the doctors. The conscience clause in section 4 of the 1967 Abortion Act exempts anyone from a duty to take part in treatment to which he or she has a conscientious objection. Official guidelines aim to protect against discrimination those who exercise this legal right.

Supporters of the 1967 act argue not only that the conscience clause is being complied with in practice but that this is at the cost of failing to provide an accessible abortion service in many parts of the country. Critics claim that the clause is not working and is being deliberately flouted by senior clinicians putting pressure on juniors and by health authorities in appointing consultants. Each side put its case to the committee.

The liberals, whose best known witness was Mrs Wendy Savage, relied chiefly on practical evidence from the operating theatres. They were adamant that doctors with a conscientious objection would never be obliged to recommend or perform an abortion against their will, though it was admitted that some junior doctors may reluctantly help with patients who have abortions. They criticised general practitioners who stretched their own moral objection to the point of professional immorality by delaying the referral of women for abortions.

The conservatives were more concerned with what went on in the interview room, concentrating their fire on the career impediment of the conscience clause. One of them, Mr Jonathan Brooks, aged 41, had felt it necessary to remain anonymous until he was confirmed in a consultant appointment at Hinchingbrooke Hospital, Huntingdon, which he takes up tomorrow after 35 unsuccessful applications. "In each case you do not know precisely why you were not appointed," he said.

Doubting that it had anything to do with his golf handicap, Mr Brooks noted a correlation between the rejections and interviews where he was grilled hard about his conservative attitude to the Abortion Act. A fellow witness told how her chief had alerted his cronies on interviewing panels, "Watch out for this woman. She won't do abortions." To stand up and be counted when applying for a job took courage, it was said.

Yet in the end, the liberals and conservatives along with the committee itself seemed equally attracted by one solution first mentioned by Mrs Savage. This was to separate abortion from general gynaecology by setting up specialist units to deal with terminations and fertility control. They would be staffed by doctors and nurses who were sympathetic to abortion and would protect those who did not want anything to do with it.

The idea had general support with a reservation on the medical side that to combine fertility with abortion might exclude good people from family planning work. And there was a suspicion from antiabortion MP Ann Widdecombe that the proposal would result in more, not fewer, abortions.

No alternative to NHS

The *BMJ* occasionally prints the reaction of doctors who unexpectedly find that being put in the position of customers of the NHS modifies their views of the service. Does the experience have the same effect on MPs? I tested it on Conservative MP Robert McCrindle (Brentwood and Ongar), who has just returned to the Commons in good shape after five months' absence for treatment of a liver tumour.

Mr McCrindle was last quoted in this column almost a year ago at the height of the BMA campaign, when he said that he resented doctors subjecting their patients to "black propaganda." After his lifesaving experience in both private and NHS hospitals Mr McCrindle now says:

After NHS treatment Mr Robert McCrindle has praise for clinicians but less for the administration

> At the end of the day, as I had occasion to discover, the NHS alone provides the service required to treat serious illnesses. In clinical and nursing terms there remains no finer service anywhere in the world. The abiding recollection I have is that private treatment is fine up to a point. But beyond that point there never will be in my judgment any alternative to the NHS, which is all the more reason why people like me should give it maximum support.

But while experience of what he called the "sharp end" has enhanced his opinion of the clinical excellence of the NHS, Mr McCrindle wishes he could say the same about its administration. A mislaid report on a computed tomogram which had to be repeated was only one example of several mishaps. The practical lesson he learnt from his time in hospital was that the NHS reforms had his total support so far as they aimed at streamlining the management. Since Mr McCrindle is often sceptical towards what the government is up to the whips may welcome him back with some relief.—JOHN WARDEN

Colleges and peers want NHS evaluation trials

The Archbishop of Canterbury has followed the example of some Cabinet members and is to retire early. The Baltic states are keen to retire from the Union of Soviet Socialist Republics. The Mid-Staffordshire voters want Margaret Thatcher's premature retirement. Doctors would like the Secretary of State for Health to take a trial retirement (or at least introduce some trials of his NHS reforms). But the conference of local medical committees decided not to invite the General Medical Services Committee to retire early (p 880). Nor, I can reveal, does the secretary of the BMA wish to retire, as a confused reporter at the conference discovered when, mistaking the secretary for an angry general practitioner, she inquired whether he was prepared to resign.

It was a curious conference. Much anger flowed round the floor, some speeches had their fiery moments, but the final decisions were hardly explosive. Representatives left no doubt about how angry their constituents were about the contract, rejecting it without a dissenting vote "as being ill considered and harmful to the medical welfare of the population." Yet having earlier shown their defiance of the platform by bringing to the head of the agenda a motion of no confidence in the GMSC, representatives seemed to run out of steam, rejecting the censure motion along with motions to call for ballots on resignation and sanctions.

Michael Wilson's fighting defence

I was surprised that the proposal to hold a ballot among general practitioners on whether to introduce sanctions was lost—albeit by five votes in 300. I thought that the widespread frustration among general practitioners would at least find expression in a ballot, and I heard doctors afterwards surmising that they would be roasted when they returned to their LMCs. Dr Eric Rose from Buckinghamshire argued cogently enough for a ballot, but Michael Wilson's fighting defence of the GMSC's policy to monitor the contract and then counterattack must have swung a sufficient number of representatives behind the platform to defeat Buckinghamshire. And, remember, the conference comprises representatives with a free vote and not delegates mandated to follow their local committees' decisions, so debates can influence policy decisions.

As regular readers know—and I have some—I believe the conference took the realistic course in rejecting militancy. It can be harder to be non-militant; such a policy smacks of wimpishness in the face of a bullying minister. But a ballot on sanctions would have offered little more than a safety valve to disgruntled doctors. The event would certainly have been manipulated by the media, irritated the public, damaged the profession, been brushed aside by Kenneth

Clarke—who, bad opinion polls not-withstanding, can count on a large parliamentary majority for two more years—and handicapped the campaign against the NHS bill.

Kenneth Clarke's contract is so flawed and is being imposed with such indecent haste that I believe it will quickly be shown up for the dubious package it is. Even discounting the inevitable rhetoric at representative conferences, the weaknesses in the contract described by a succession of speakers were convincing:

- The unfairness of the targets for immunisation and cervical cytology
- The risk to patients' confidentiality
- The false logic of the argument that patients will get better treatment because good doctors will attract more patients
- The anomalies in the deprived area payments—the conference even heard Professor Brian Jarman in person explain that the government had clumsily modified the deprivation index that he had proposed
- The dubious claim that patients will have greater choice
- The time spent on routine examinations of doubtful worth that means less time for the sick.

All these and more were paraded for inspection.

I believe, however, that as with the NHS review the weakest links will prove to be inadequate information systems and poor management. Many practices do not have the computerised systems necessary to run the new contract effectively and many family practitioner committees are understaffed and under pressure. For example, I hear that one large committee has a backlog of 300 000 patients' changes of address, which may take until September to rectify. Meanwhile how will doctors' capitation and other fees be calculated? In particular those practices with manual records may find themselves at a disadvantage in preparing the up to date figures of their practice activities.

The whole contract exercise epitomises this government's penchant for slick public presentation of ill thought out money saving policies dressed up as progress and hastily introduced. A typical glossy presentation in general practice this week was the announcement of £360m allocated to family practitioner committees in 1990-1 "to fund direct reimbursement to general practitioners of their expenses on practice staff and improvements in premises." Described by Kenneth Clarke as a "huge increase in public spending by the government," the money looks to be no more than the inflation adjusted directly reimbursed sum paid to practices every year—except that whereas in past years the expenses have been reimbursed without restriction this year the sum is being earmarked in advance. "It is the first time," states the minister, "that family practitioner committees have been given cash allocations for these areas of expenditure. We are giving out the money in this way in order to give local committees scope to target local priorities more effectively." In reality the minister's press statement is a verbose, coded, self congratulatory effusion announcing the 1990-1 cash limit for premises and staff.

Royal colleges' dislike

In an unusual show of public unity the doctors' colleges and faculties and the nurses' and midwives' colleges along with other health professions have jointly declared their views on the government's plans to introduce market forces into the NHS. Like the BMA the colleges do not like them (p 831). The NHS bill has just started its passage in the House of Lords and an all party group of peers—supported by the royal colleges—hopes to persuade ministers to rethink their plans to change the health service. The aim is to get the government to use trials in some regions to evaluate the proposals. The BMA has been demanding this: that broad support shows, as the association puts it, "a unanimity of feeling across all the health professions." So, please listen, Mr Clarke.

I presume that the secretary of state hopes to head off any opposition from the colleges by inviting them to join his quality control initiative (17 February, p 474). He has deliberately excluded the BMA from that exercise. He makes no secret of his contempt for the association, which he sees simply as another union—and presumably he believes that such an organisation cannot be interested in quality of service. The fact that since the NHS was launched the BMA has provided a wide range of valued professional advice to the service is ignored by Mr Clarke. I am a mite suspicious, however, that the secretary of state will try to use the colleges as a cloak of respectability for his commercialisation of the NHS.

Finally, let me publicise two important examples of BMA democracy: firstly, the council's comprehensive annual report is in the centre of this issue; secondly, candidates for the council's biennial election are at p 884. Please read the first and vote in the second.

SCRUTATOR